

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER 62-049637

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 3699

FILED JAN 16 1963

VS 300
Rev. 4/59

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY ST. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY S | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Robertson, Mo. | | c. CITY OR TOWN Missouri ST. LOUIS | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mayberry Nursind Home | | d. STREET ADDRESS 5334 Maple | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First OLIVER Middle HOLLOWAY Last | | 4. DATE OF DEATH Month Dec. Day 16, Year 1962 | |
| 5. SEX M | 6. COLOR OR RACE Negro | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12/12/80 |
| 9. AGE (last birthday) 82 | | 10. IF UNDER 1 YEAR Months 0 Days 4 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Disabled Freight Handler, N.Y.C.R.R. | | 10b. KIND OF BUSINESS OR INDUSTRY Shelbyville, Ky. | |
| 11. BIRTHPLACE (City and state or country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Thomas | | 13b. MOTHER'S MAIDEN NAME Anna (unknown) | |
| 14. NAME OF HUSBAND OR WIFE Mamie Holloway | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | |
| 16. INFORMANT William Holloway, 4554 Ashland | | 17. ADDRESS 5 | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension Heart Disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION St. Louis, Mo. | |
| 21. I attended the deceased from Oct 1962 to Dec 16, 1962 and last saw him alive on Dec 16, 1962 Death occurred at _____ p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | 22a. SIGNATURE J.W. Brand (Degree or title) M.D. | |
| 22b. ADDRESS 5701 Cornwell | | 22c. DATE SIGNED 12-16-62 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVED | 23b. DATE 12/20/62 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. |
| 24. FUNERAL DIRECTOR Charles J. Gates, Jr., 4107 Finney | | 25. DATE RECD. BY LOCAL REG. 12-18-62 | |
| 26. REGISTRAR'S SIGNATURE John B. Murphy M.D. | | | |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by Raymond Dickson, Student Embalmer No. 665

working under my personal supervision.

Student Raymond Dickson Signed Quinton Swan
Signature of Student Embalmer

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.